

Meningococcal Disease Supplemental FormIn addition to the **National Bacterial Meningitis and Bacteremia Case Report Form** OMB No. 0920-0009

PATIENT NAME (Last, First, M.I.)°

RISK FACTORS FOR DISEASE

Was the patient a contact of a confirmed or presumptive case in the 60 days before onset? " yes " no " unknown

If yes, was prophylaxis recommended? " yes " no " unknown

was patient under 60-day surveillance? " yes " no " unknown

Did the patient have any respiratory disease in the 2 weeks before onset? " yes " no " unknown

Does the patient report any underlying chronic illness? " yes " no *If yes,* what illness? _____

Is the patient a smoker? " yes " no " unknown

If yes, cigarettes per day: _____ (number)

years of smoking: _____ (number)

Does the primary caretaker or person who spends most time with patient smoke? " yes " no " unknown

If yes, excluding case:

How many people in household smoke? _____ (number)

How many household smokers smoke at least:

one cigarette a day? _____ (number)

one pack a day? _____ (number)

If patient is a child:

Has the patient entered a new school or daycare within the last 6 months? " yes " no " unknown

Does the patient participate in any regularly scheduled organized group activities? " yes " no " unknown

If yes, specify: _____

Was the patient out of the U.S. in the 60 days prior to onset? " yes " no " unknown

If yes, was vaccine recommended prior to travel? " yes " no " unknownWas the patient ever immunized against *Neisseria meningitidis*? " yes " no " unknown*If yes,* what was the date of the immunization? ____/____/____

Vaccine product information (brand, types, etc): _____

For College Students With Meningococcal Disease Only:**College Student Supplemental Case Report Form****State Reporting Case: MI****Case ID:** _____**Date of Report:** ____/____/____**1. How was the case identified (check all that apply):**" isolation of *N. meningitidis* from blood" isolation of *N. meningitidis* from CSF

" culture from other sterile site, specify _____

" positive meningococcal antigen test in CSF

" other, spec.: _____

2. Year of School:

1" Freshman 2" Sophomore 3" Junior

4" Senior 5" Graduate Studies 9" don't know

3. Full- or Part-Time student: (as defined by college):

1" full-time 2" part-time 9" don't know

4. Housing:

1" apartment 2" dormitory

3" communal living (i.e., fraternity/sorority, college housing)

4" single family home with family only

5" single home with other students

9" don't know

10" other, spec. _____

5. Full name of College/University: _____**6. Has patient received meningococcal vaccine:**" yes " no *If yes, when:* _____**7. Has patient received any information about meningococcal disease from their academic institution?**" yes " no *If yes, when:* _____**Comments:** _____**PLEASE FAX THIS FORM TO THE MDCH AT:
(517) 335-8263**